Title: SYSTEMS AND METHODS FOR TRACKING EMPLOYEE LEAVES UNDER THE FMLA Inventor(s): Rachel S. Lieberman et al. Application No.: 09/752,274 Attorney Docket No.: 60709-00019 Attorney: Daniel M. Fitzgerald; Phone: (314) 621-5070

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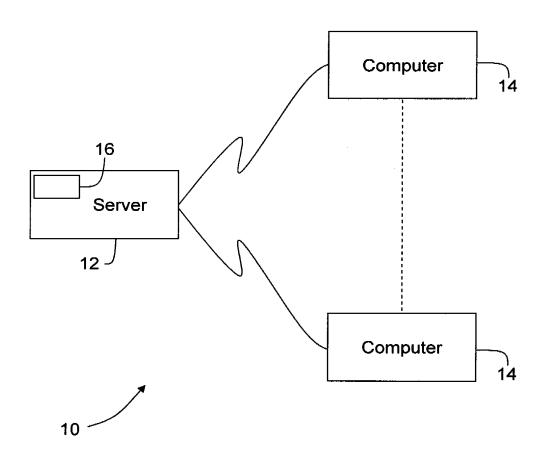


FIG. 1

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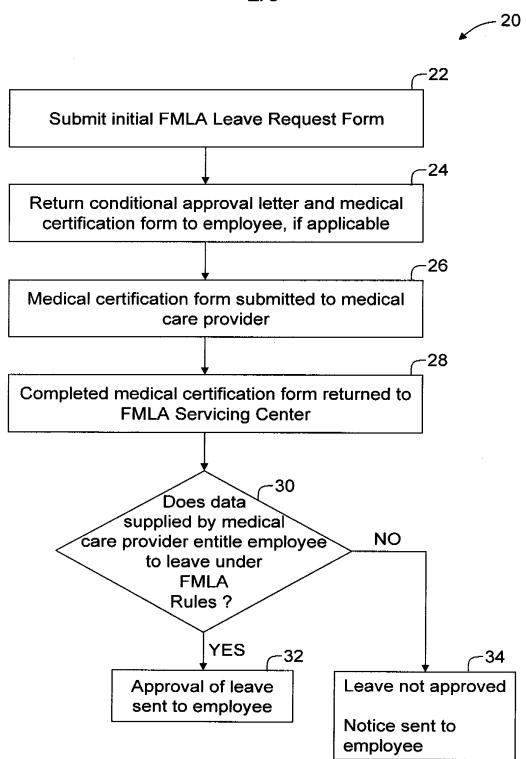


FIG. 2

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	12	3				
Initial FMLA Leave Request Form						
Any incomplete information will delay the processing of this request						
If you ha	ve any questions, please call the FMLA	Center toll free at 877-555-FMLA/(877)-55	5-3652			
52 Form sub	omitted by:86		66 Date:			
Employee Name	if different from employee	GE Capital Business SS Ņo: 123-45-6789	9			
Home address:		64				
Home Phone:	(Street) 70	(City) 74 HR Rep.: (State)	(Zip)			
II \ \ -	00 NGR:	76 HR Rep. phone:				
Date of Hire:	(mm/dd/sy)	- HR Rep. phone:				
Work Location:	(City/State)	Current Work Schedule: (Days/Hours)	per week)			
		Check this box if you are applying for disability (note; you must call the disability center to apply for d	benefits			
_8	0 84ノ	note. you must can the disability contest to apply for a				
C < 54		(56 Table 251 and 1				
(2) TR	leason for Leave	(3) Type of Leave				
Please check (/) the reason for the leave you are requesting	Please check (/) the type of leave you are requ	esting			
	Inpatient hospital stay, recovery from	Full, Continuous Leave				
	stay or treatment related to stay.	Requested time period:				
<u> </u>	-92	Begin date: 110 to (mm/dd/yy) to (mm/dd/y	12 end date			
HOSPITAL PREGNANCY	Incapacity due to pregnancy and	(mm/dd/yy) (mm/dd/	yy) Ond data			
	prenatal care (before the child is born). Expected delivery date:	∕ 114				
	or 104	Reduced Schedule				
NEW CHILD	Time to care for a newborn child or a newly placed adopted or foster care	Requested reduced work schedule:				
94 96 	child (for moms and dads).	116hrs./day				
	Too sick to work for more than three consecutive days (including non-work days), and saw a health care provider	118hrs./week				
	twice; Or	120days/week				
7	Too sick to work for more than three consecutive days (including non-work days), and saw a health care provider	Time period for which you are request reduced schedule:	ing the			
MEDICAL	once and given a continuing regimen of treatment (e.g., therapy, medication);	Begin date: 122 to 12 (mm/dd/yy)	4 end date			
CONDITION	Or	126 − 126				
\	Incapacitated by or out to receive treatment for a serious chronic or	Intermittent Leave (i.e., occasional, e	episodic)			
100-/	permanent her a serious chronic or permanent health condition (e.g., asthma, diabetes, cancer).	If the medical condition is occasional or require a specific time period for cover FMLA (up to 1 year maximum)				
	To take care of/provide support for a sick eligible family member who falls into one of the categories above (except care of a new child).	Begin date: 128 to 130 (mm/dd/yy)	end date			
	me of family member & relationship to you					

FIG. 3

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		fodical Cort	(1)(2)(3)	3 <i>)</i> FMLA - Employ		
				ovider for certifica		
For questi	ons regarding th	is form call 877	-555-FMLA/877-55	5-3652, Return to the	FMLA Center by _	
Name:	John Smith	<u>1</u>	48	SS No.:	123-45-6789	<u>15</u> 0
••(1)•• Rea	son for Leave	e - Medical Pr	ovider must ched	ck() any and all	that apply. ••	•••••
PREGNAM	ICY - I certify the	nat the above p	atient is/has bee	n/will be:		
142 Inc	apacitated* due	e to pregnancy.				
Red	eiving prenatal	care Expecte	ed delivery date: _		<u> </u>	
MEDICAL	CONDITION -	I certify that the	above patient is	/has been/will be:		
lnc.	apacitated* for dition.	more than 3 c	onsecutive day	s and received trea	tment at least 2 t	imes for this
Inc.	apacitated* for scribed a regime	more than 3 c	onsecutive days	s and received trea herapy. Rx).	tment for this con	dition and
☐ Inc: 1) r	apacitated* by	or out of work c visits/treatm	to receive treatment and 2) contin	nent for a chronic s nues over extended	erious health cond period of time and	dition which d 3) causes
☐ Inc	apacitated* by tment (i.e. Alzh	a permanent/leimer's, severe	ong-term condit	ion for which patier	nt is undergoing co	ontinuing
Out		lergo examina	tion/testing for a	condition that wou	ld likely fall into or	e of the
	o work or perfe	-	•			
HOSPITAL	STAY - I certify	y that the above	e patient is/has b	een/will be:		
☐ Inp	atient in a hosp	oltal, hospice,	or residential m	edical care facility.		
Out	of work to recei	ve treatment f	or a condition co	nnected to previous	inpatient stay.	
Red	overing from in	npatient stay a	nd incapacitated	d (unable to work or	perform regular d	aily activities).
••(2)•• Date	s/Time of Lea	ave - Medical F	Provider must ind	icate dates and time	es of leave • •	•••••
Continuo	is Leave: (If Re	quested) - I ce	rtify that the abov	e patient has a med	dical need for leav	e as described.
144 Requested	time period - B	egin date:	(mm/dd/yy)	to	(mm/dd/yy)	end date
				atient has a medica		
Requested	reduced hours	schedule	hrs./da	/ hrs.	/week	days/week
Requested	time period - B	egin date:	(mm/dd/yy)	to	(mm/dd/yy)	end date
Intermitter medical ne	nt (i.e., occassi ed for leave as	onal, episodio described.		uested) - I certify tha		nt has a
146 Requested	intermittent sch	edule	hrs./day	hrs./w	eek c	lays/week
Indicate ap	proximate durat	ion of medical	condition - Begin	date:(mm/dd/yy)	to	end date
••(3)•• Sigr	nature Stamp	- Medical prov	/ider must sign a	nd return form to the	FMLA Center	/y <i>)</i>
Medical Provide Signature:		_152	Phone:		54 Fax: _	_156
Print Name:		_158		_Type of Practice: _		60
Address:		<u>162</u>			(field of specialit	y,if any)
				(city)	(state) (zi	p)

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		and				—
	ı	(1)(2)(3)			
Me	dical Certifica	tion for FM	LA - Family I	Member		
	orm to your famil				1.	
For questions regarding t	_		5-3652. Return to	the FMLA Center		7 4
142 Patient Name:Joh	nn Smith 1	72	Relationship to E	:mployee: <u>S</u>	PUUSE /	74 = 5
Kemployee Name: ⊒an	ice Doe	40	SS No.:	123-45-6	789	50 —
••1 •• Reason for Leav	ve - Medical Prov	vider must che	ck(🛩) any and	all that apply.	• • • • • • • • •	•••
PREGNANCY - I certify	that the above pa	tient is/has bee	n/will be:			
☐ Incapacitated*du	ie to pregnancy.					
Receiving prenate	al care Expected	delivery date:				
MEDICAL CONDITION	-I certify that the	above patient i	s/has been/will b	oe:		
Incapacitated* fo condition.	or more than 3 co	nsecutive day	s and received t	reatment at leas	st 2 times for this	
	or more than 3 co men of continuing			reatment for this	s condition and	
Incapacitated* by 1) requires period episodic or conti	dic visits/treatme	nt and 2) contin				
Incapacitated* by treatment (i.e. Alz			tion for which pa	atient is undergoi	ng continuing	
Out of work to ur categories listed a	ndergo <mark>examinatio</mark> above or require ir	on/testing for a patient stay.	a condition that v	vould likely fall ir	ito one of the	
* Unable to work or per	form regular dall	y activities.				
HOSPITAL STAY - I cer	rtify that the above	e patient is/has	been/will be:			
	spital, hospice, o	•		litv.		
144 Out of work to rec				•	v.	
- · · · · =	inpatient stay and		•	•	•	3).
<u></u>		-	,	,	•	
••(2)•• Dates/Time of L	eave - Medical Pr	rovider must ind	licate dates and	times of leave fo	or the employee • •	•••
Continuous Leave: (If Representation of the beneficial psychological of following time period:	tequested) - I certi comfort to spouse	ify that the abov , child(who is u	ve employee is n nder 18 or incap	eeded to care fo able of self-care	r, or provide), or parent for the	;
Requested time period -	Begin date:		to _	(mm/dd/y	end da	ite
Reduced Hours: (If Req for, or provide beneficial parent for the following ti	psychological com	that the above of the fort to spouse,	employee needs child (who is un	reduced work he der 18 or incapa	ours to take care ble of self-care), o	ρr
Requested reduced hour						
Requested time period -	Begin date:	(mm/dd/w)	to	(mm/dd/s	end da	ite
Intermittent (i.e., occase intermittent leave to care incapable of self-care), or	sional, episodic) for, or provide ber	Leave: (If Req	uested) - I certify	v that the above	emplovee needs	
146 Requested intermittent so	chedule	hrs./day	hrs	s./week	days/week	
Indicate approximate dur	ation of medical co	ondition - Begir	date:	d/vv) to	end da	ate
••(3)•• Signature Stam	p - Medical provid	der must sign a	nd return form to	the FMLA Cent	er ••••••	
Medical Provider Signature:	~152	Phana		-154 .	-av. ~15	6
Print Name:	<u>158</u>	rnone:_	Type of Practic	-154 Field of sp	<u>/ 160</u>	_
Address:	~162			(field of sp	eciality, if any)	_
A441 655.			(city)	(etata)	(zin)	